207 CYE 13 -17 PRIMARY CARE ENHANCED PAYMENTS

EFFECTIVE DATES: 01/01/13, 07/01/16, 10/01/17

REVISION DATES: 01/15/15, 04/21/16, 07/11/18

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. Section 1202 of the Affordable Care Act requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. These reimbursement requirements for the enhanced payments apply to payments made for dates of service January 1, 2013 through December 31, 2014. This Policy establishes the Contractor requirements for Primary Care Provider enhanced payments and the cost settlement of those payments.

II. DEFINITIONS

AFFORDABLE CARE ACT (ACA)	Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (PPACA).
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
ENCOUNTER	A record of a health care-related service rendered by a provider registered with AHCCCS to a member who is enrolled with a Contractor on the date of service and has been adjudicated by the Contractor.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S §36-2905 for payments made to the Contractors for the contract year.
PRIMARY CARE SERVICES	For the purposes of this Policy, primary care services are described in Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act and 42 CFR 447.400(c).

III. POLICY

A. QUALIFYING SERVICES

Federal regulations require state Medicaid programs to pay qualified Primary Care Physicians (PCPs) at fees that are no less than the Medicare fee schedule in effect for Calendar Years (CY) 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare Conversion Factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes.

The increased payment requirements apply to primary care and vaccine administration services described by the following codes:

1. CPT Evaluation and Management (E&M) Codes 99201 through 99499; and

2. CPT vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 or their successor codes.

In addition, vaccines administered to children under the Vaccines for Children (VFC) program, indicated by appending modifier 'SL' to the appropriate CPT code, must be reimbursed at the lesser of the billed charge or the enhanced regional maximum VFC fee.

B. QUALIFYING PROVIDERS

In order to qualify for the Enhanced Payments, the physician must:

1. **Self-attest** as practicing in family medicine, general internal medicine or pediatric medicine or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties.

AND

2. **The physician must also self-attest to being either**:
   a. Board certified with a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties

   OR

   b. A PCP or subspecialist who works in one or more of the above specialty designations **but who does not** have a certification specified in number 2a above **but** has billed at least 60% of Medicaid (AHCCCS) services using the E&M and vaccine administration codes listed in Section III (A). For physicians registered as AHCCCS providers in Calendar Year (CY) 2012, the 60% billing requirement

applies to Medicaid (AHCCCS) claims billed during the 2012 calendar year. For physicians who registered as AHCCCS providers in CY 2013 or 2014, the 60% billing requirement applies to Medicaid (AHCCCS) claims billed for the month prior to the attestation.

Increased payment rates may apply to Nurse Practitioners (NP) and Physician Assistants (PA) *when they practice under the supervision of a qualified physician.* These physician extenders are not permitted to attest on their own; supervising physicians must include the names of subordinate physician extenders on their attestations.

AHCCCS has elected to extend the enhanced payments to these same qualifying providers when they provide services to KidsCare members.

Physicians who have successfully attested on or before April 30, 2013 will be paid the enhanced fee retroactively for dates of service from January 1, 2013 or the begin date of their qualification whichever is later, through the attested end date or December, 31, 2014 whichever is earlier for all qualified primary care services. Physicians successfully filing the required Attestation on or after May 1, 2013 will be paid the enhanced fee from the time the Attestation is received, through the attested end date or December, 31, 2014 whichever is earlier.

C. PCP ENHANCED RATES

Eligible PCP must receive the full benefit of the enhanced payment at the rate mandated for eligible services rendered. The enhanced payments apply for the services described by the CPT codes listed above provided during CY 2013 and 2014. The primary care enhanced rates can be referenced in fee schedule screen RF144 in the AHCCCS payment system.

The Contractor is required to reimburse at the lesser of billed charges or the enhanced rate. The Contractor may pay above the enhanced rate, depending on specific contractual arrangements with a provider, but may not apply any quick payment or other contractual discounts to the enhanced rates. Provider type percentage pay discounts mandated by AHCCCS Policy are allowable. If a Contractor has sub-capitation arrangements that are less than the enhanced rate, the Contractor is obligated to provide additional payments to providers to ensure that every unit of primary care services provided is reimbursed at the enhanced rate required under Section 1202 of the Affordable Care Act.

D. ENCOUNTER SUBMISSIONS

The Contractor is required to report PCP enhanced payments on all impacted encounters. AHCCCS has developed system updates for submitted encounters in order to determine if the PCP enhanced payment criteria is met. The Contractor must include indication of payment of the enhanced rates versus the non-enhanced rates within submitted encounters. PCP enhanced payments will not be included in reconciliations or capitation rate setting.

PCP enhanced rate encounter flow, criteria, and example scenarios can be referenced in Attachment A.

E. COST-SETTLEMENT PAYMENTS

Enhanced payments for qualifying claims by qualifying providers with dates of service on or after January 1, 2013 will not begin until after August 1, 2013, but will be made retroactively to January 1, 2013 or the individual provider attestation date whichever is later.

AHCCCS will reimburse the Contractor for PCP enhanced payments made to providers via a quarterly cost settlement process. Cost settlement payments to the Contractor are based on the Contractor's actual adjudicated encounters and will be paid outside of capitation rates. AHCCCS will consider all adjudicated/approved encounter data flagged by AHCCCS as eligible for PCP enhanced payments.

On a quarterly basis the Contractor will be sent a report by the AHCCCS DHCM Finance Unit with all Encounter Claim Reference Numbers (CRNs) (and other key identifying data) that have been reported and validated as correctly paid by the Contractor using the enhanced rates since the last quarter (based upon the encounter adjudication status date).

The Contractor will be given a two-week period to review and reconcile claims payments to the cost settlement report. Once the Contractor agrees on the reported CRNs and amounts, the cost settlement payment including the premium tax component will be made based upon the finalized list of CRNs. This will happen up until the Federal two year claiming timeframe expires. PCP enhanced payments are eligible for quarterly premium tax reporting, see ACOM Policy 304.

In the event that a provider's eligibility for enhanced payments is subsequently revoked due to audit or any other reason, the Contractor shall recoup enhanced payments made after the effective date of the revocation. In the event that the supervising physician's qualification is revoked, then the supervised NP and PA will not qualify for enhanced payments. The Contractor will be required to submit all reprocessed claims in their reported encounters. These encounters will be included in the quarterly cost settlement process as payments due to AHCCCS.

In the event that a provider is retroactively flagged as Board Certified or Attested (60% or new provider) or loses this designation as noted above, the Contractor is expected to identify and automatically reprocess any impacted claims for enhanced payments. It is expected that this reprocessing will be conducted by the Contractor without requirement of further action by the provider.

F. AHCCCS AUDITS

In accordance with federal regulations, for 2013 and 2014 AHCCCS must conduct annual random sample audits of physicians submitting attestations regarding both the Board

Certification and the 60% billing requirements [42 CFR 447.400(b)]. If a physician is determined to not meet the requirements, the physician will receive notice from AHCCCS Office of the Inspector General (AHCCCS-OIG), informing the provider that the requirements for receiving enhanced payments have not been satisfied and that the AHCCCS Administration and AHCCCS Contractors will recoup any enhanced payments made in error. In the event that the supervising physician has not met the qualifications, then the supervised NP and PA will also not qualify for enhanced payments and enhanced payments will also be recouped.

Prior to recouping the enhanced payments from the provider, the AHCCCS Administration and its Contractors will send written notification to the provider informing the provider of the upcoming recoupments and will provide information about the dispute resolution process.

1. **Disputes Pertaining to Recoupment of Enhanced Payments**

   The physician may contest the recoupment of the enhanced payments by filing a claim dispute with the Contractor. Prior to any recoupment action, the Contractor and the AHCCCS Administration, whichever is applicable, will notify the provider of the recoupment and will provide information about the dispute resolution process.

   The dispute resolution process will be in accordance with the:

   - Contractor Provider Claim Dispute Process for managed care claims
   - A.A.C. R9-34-401 et seq.
   - A.R.S. §41-1061 et seq.
   - Managed Care Contracts, Section F, Attachment F2, Provider Claim Dispute Standards
   - RBHA Contracts, Scope of Work, Section 13, Grievance and Appeal System Requirements, Claim Disputes

2. **Disputes Pertaining to Enhanced Payment Amounts**

   The Contractor is responsible for ensuring that its payment system accurately reflects the information that was received from AHCCCS and that the enhanced payment to the provider is consistent with this information. If the Contractor does not make the proper payment to the physician or supervised NP or PA based on the information provided from AHCCCS, the provider may file a claim dispute with the Contractor challenging the payment amount.